Mental Health Series

A Patient's Right to Die: Physician-Assisted Suicide

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INTRODUCTION

The right of an individual to die a natural death without the administration of artificial life support procedure now thoroughly entrenched in American life. The US Supreme Court has recognized the right of an individual to autonomy in the making of decisions relating to his own health and medical treatment. Palliative care to relieve suffering is permitted in the United States even if it might hasten death.[1] However, states have drawn a line between palliative care and assisted suicide. Hastening death by assisted suicide has remained controversial and illegal in most states.

The American Medical Association has discouraged allowing physicians to participate in assisted suicide stating that it is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.[2] Some physicians argue that clinical histories, such as Freud's who deliberately ended his life with the assistance of his trusted physician after suffering an invasive skin malignancy, should be an impetus for abandoning the prevailing American "taboo" against assisted suicide. These physicians argue that assisting with the cessation of life, in certain cases, is very much in the tradition of rational and ethical medicine.[3]

This paper examines the current legislation and prevailing attitudes regarding assisted suicide in Tennessee as well as other states.

TENNESSEE LEGISLATION

Between 1978 and 1990, twenty-three states litigated issues about terminating medical treatment. Tennessee was one of these states. The first of Tennessee's advance directive statutes was called the Tennessee Right to Natural Death Act, enacted in 1985. The Tennessee General Assembly has declared it to be the law of the state that every person has the fundamental and inherent right to die naturally with as much dignity as circumstances permit and to accept, refuse, withdraw from, or otherwise control decisions relating to the rendering of the person's own medical care specifically including palliative care and the use of extraordinary procedures and treatment.[4]

As a result, Tennessee citizens were given the right to make a Living Will in 1985. This right was amended and expanded upon in 1991 to allow individuals in making a Living Will, to decide whether to withhold feeding tubes, give blood, administer food, etc.[5] In addition, in 1990, Tennessee adopted the Durable Power of Attorney for Healthcare Act. This statute permitted individuals to designate attorneys as their agents to make a health care decision in the event that they become incapable of making such decisions themselves.[6]

Both the Living Will and Durable Power of Attorney statutes exempt physicians from criminal and civil liability if they comply with their provisions.[5,6] However, the physician-assisted suicide statute limits these exceptions.[7]

Physician-assisted suicide has been a class D felony in Tennessee since 1993. The right of a competent person to end a life of suffering clashed with the state's interest in preservation of life and the prevention of suicide. It is not a crime, under the statue, to furnish medication or perform medical procedures if they are intended to relieve pain or discomfort. It is not a crime to prescribe medication that is intended to relieve pain if even if those measures hasten death. But the intention cannot be death.[7]

Tennessee's statutes were already enacted when, in 1997, the Supreme Court unanimously agreed that competent, terminally ill patients do not have a constitutional right to commit suicide or to obtain assistance with committing suicide. Almost every state has enacted some sort of prohibition against assisted suicide. The Supreme Court concluded that it is permissible for physicians to aggressively treat patients' pain as long as the intent of the physicians is not to deliberately hasten patients' death.[8]

However, this Supreme Court decision raised questions about how physicians can provide palliative care. The Court suggested that access to palliative care may be protected by the Constitution.[9] The right of patients to be free from suffering could limit physicians' ability to raise conscientious objections, since they must respect their patients' refusal of treatment, even if those decisions do not reflect their own personal values.[10] States that have laws, which restrict the prescription of narcotics to terminally ill patients, may be in conflict with a putative constitutional right to palliative care. Such conflicts might be resolved through future state legislation.[9,11]

Although at time confusing to physicians, when administrating pain relief to terminally ill individuals, it is the intent of the physician who prescribes this medication that designates the act of prescribing to be either palliative care or assisted suicide. The law attempts to use objective evidence to measure a physician's subjective intent. Physicians cannot say that they intended to relieve pain, which hastened death, unless their words and actions are consistent with that purpose. Likewise, physicians cannot avoid responsibility for what appears to be an assisted suicide simply by saying that their purpose was to treat pain rather than hasten death. Their assertions may seem improbable to juries and other interested parties.[12,13]

OREGON LEGISLATION: AN EXCEPTION TO THE RULE

The 1997 Supreme Court decision did not prohibit states from allowing assisted suicides to occur, it proclaimed that individuals do not have a constitutional right to assisted suicide. On October 27, 1997, physician-assisted suicide became a legal medical option for terminally ill Oregonians. The Oregon Death with Dignity Act allows terminally ill residents to obtain prescriptions from their physicians and the use of those prescriptions for self-administered, lethal medications. While this type of physician-assisted suicide is permissible under the Act, euthanasia (where a physician or other person directly administers a medication to end life) is prohibited. Further, the Act states that ending one's life in accordance with the law does not constitute suicide.

Oregon's Death with Dignity Act put safe-guards in place in order to ensure that only adults meeting certain criteria may be eligible for physician-assisted suicide. Some key safe-guards include that an individual:

- must be over the age of 18;
- must meet the Oregon residency requirements set for in law;
- must have a terminal illness with a life expectancy of no more than six months;
- must be "capable" of making such a decision (meaning that the court, the patient's

attending physician or consulting physician, psychiatrist or psychologist determines that the person has the ability to make and communicate health care decisions to health care providers);

- if indicated, must have at least on counseling session with a state licensed psychiatrist or psychologist for the purpose of determining that the patient is capable in that he is not suffering from a psychiatric or psychological disorder (such as depression) that could cause impaired judgment; and
- must make an oral and a written request using a designated form and witnessed and agreed upon in writing by two individuals – one of whom must not be related in any way or stand to gain from the individual's death.

The attending physician and a consulting physician must agree and confirm that the individual meets criteria for physician-assisted suicide. The patient must make an oral request to his attending physician, supporting his earlier oral and written requests, no less than 15 days after making the initial oral request to his physician. The physician must then offer the patient to rescind his request. Then, the physician may write a prescription for the patient to take in order to end his life.[14]

Fewer Oregonians used the Death with Dignity Act in 2001 than in 2000. According to the fourth annual report of the Oregon Department of Human Services, the number of individuals who used physician-assisted suicide decreased from 27 to 21. The number of deaths by assisted suicide remains small in relation to the 29,541 total Oregon deaths in 2000. For each year, the data show that the patients were older, highly educated, and most had cancer.[15]

ATTITUDES OF PHYSICIANS & PATIENTS

Many physicians oppose assisted suicide. Of those who do support assisted suicide, they believe that there are types of suffering that do not fall within the Supreme Court's rulings and that present strong arguments for assisted suicide. For instance there are a few terminally ill patients whose pain cannot be effectively relieved although they are receiving optimal palliative care. They include:

- patients with cancer of the head, neck and/or esophagus who cannot swallow their secretions;
- patients with cancer who experience intractable bleeding due to disseminated intravascular coagulation; and
- patients with AIDS who suffer from refractory diarrhea.

Such patients can be sedated so that they are no longer conscious of their symptoms, but they will not be allowed peaceful or dignified deaths.

Some terminally ill patients agree with their physician proponents. They believe that they will lose their dignity and integrity if they have to live out their remaining days unconscious in order to obtain relieve from their insufferable pain. Many competent, terminally ill individuals request physician-assisted suicide, not because of excruciating pain, but because their lives have become unacceptably undignified to themselves.[16,17]

A grant from the National Health Research and Development Program of Health Canada funded a study of patients receiving palliative care for advanced cancer. Seventy patients (32 men and 38 women) took part in a survey using in-depth semi-structured interviews. Most participants (73%) believed that physician-assisted suicide should be legalized. They cited pain and the individual's right to choose as their primary reasons. Participants who were opposed to legalized assisted suicide cited religious and moral reasons as their concern.[18]

CONCLUSION

While modern medical technology has the potential for great life-extending capabilities, eventually we all face death. For some suffering a terminal illness, there may come a time when further treatment brings only agony and when the quality of a well-lived life slips away. Some of these individuals would welcome the right to make a choice not to continue their life. Many physicians feel that suicide assistance motivated by compassion for suffering will put physicians on a slippery slope. It is certain that in many states and nationwide, there will be ongoing public discussion and possible litigation to balance the need to reduce suffering and legalized assisted suicide in rare, compelling cases.[19] TM

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